DOCUMENT RESUME

ED 274 909 CG 019 413

AUTHOR Acampora, Alfonso P., Ed.; Nebelkopf, Ethan, Ed.
TITLE Women, Family Systems & the TC. Chapter 8.
PUB DATE 86
NOTE 31p.; In: Bridging Services: Drug Abuse, Human Services and The Therapeutic Community; see CG 019 406.
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Battered Women; *Cross Cultural Studies; Drug Addiction; *Drug Rehabilitation; Employed Women; *Family Problems; *Family Violence; *Females; International Organizations
IDENTIFIERS *Substance Abuse; *Therapeutic Communities

ABSTRACT

This document contains 11 papers from the ninth World Conference of Therapeutic Communities (TCs) that deal with women's issues, family systems, and the TC. Papers include: (1) "Families in the Eighties" (Cecil Williams); (2) "Women, Work & Substance Abuse" (Lois Morris); (3) "The National Federation of Parents" (Shirley Colletti); (4) "The Parents' Association in Australia" (Ian Permezel); (5) "The Family Association in Australia: Clinical Aspects" (Joe Lamberti); (6) "The Challenge of Growth & Change" (Michael Maloney); (7) "The Young Women's Group" (Leslie Tarbell); (8) "The Parenting Program at Walden House" (Ethan Nebelkopf); (9) "Addiction, Marginal Pathology & Society" (Juan Alberto Yaria); (10) "The Addict and His Family" (Miguel Angel Bianucci); and (11) "The Male Batterer" (Ricardo Carrillo). (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Ethan Nobil Kopf
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ED274909

CG 019413

CHAPTER 8

WOMEN, FAMILY SYSTEMS & THE TC

FAMILIES IN THE EIGHTIES

Reverend Cecil Williams

Glide Memorial Church
San Francisco, California

It is apparent to me that we are now moving from where we need to come from because I'm convinced that what we saw in the 70's created real havoc for us -- real problems. We were so caught up in narcissism, so caught up in gazing at our navels saying that I'm concerned about just me and that's it. But now in the 80's we're breaking out again, back into the world where the gutsy issues are. Therefore it is my own feeling that what we must do now is invent, create, to rightly understand then, for me, what we are facing here.

And this is the issue: that we must create from death. You ask Bishop Tutu and you ask the black South Africans what they have to live with every day and immediately they would say, "Death." Ask the people of Central America what they have to relate to and they would say, "Death." But you see, I'm convinced that you create from death. I was fascinated, literally, by the protest marches in South Africa and you could see the creation and the vision that was occurring from the funeral processions. People began to be ingenious enough to protest, to keep the issue before the South African government and before the world.

Now, what I really want to say is, too many times we get stuck and caught in our own situations, and what happens to us is that we hit a groove and the groove seems to be working and it sounds good and the rhythms create those things by which it feels like we're really on top of the situation and in control of the situation. But we settle down. And when we settle down, then we settle out. I'm here before you to say that, for me, every moment must be lived fully. Therefore, this is the most important moment for me. And the next moment will be important, too. But I'm not there yet. I've got to wait until I get there.

So therefore, everything that I have I give to this moment, to this experience. Because out of this experience we may be able to invent something new for humanity. Therefore it seems to me that we cannot settle in because we may settle out. What we must do, then, is be able to say, "Yes. There is power in death." Most of us have still not learned, however, the power that we can use when we say, "Yes," and also the power that we can accumulate when we really want it. A lot of people at my place are still afraid of power because, in many ways, to a lot of people power means that you become egotistical. It's bad to have a ego. You should have seen me when I didn't have an ego. And now I've got one and they say, "He's braggadocious." Yeah, I am, because I've got power now to overcome anything I want to overcome if I really want to overcome it.

Some people are so good they ain't good for nothing. And what we've got to do is invest some more "yes" power, to be able to affirm each other as well as ourselves, to be organized and bring together people, families, young people and people who are on the edge and people who have to live on the edge and people who find themselves what one might call the wretched of the earth. It seems to me that there are those of us who are going to have to live with the wretched of the earth for the rest of our lives. As so therefore we must get back from the edge.

A lot of folks want to go to the center. I'm saying to the people in the center, "You've got to come to the edge." If you really want to understand and respond to the poor of the world, if you really want to do something about the issues of oppression, the issues of starvation, if you really want to deal with the issue of people being drugged out and drugged in, if you really want to deal with the issues of how families find themselves desperately seeking some way by which they can come together again, then you've got to come to the edge. And find it. And say yes to that power. To say yes is to have the power to do several things, to take action, to do something. And the real issue here is that we talk too much about what we're going to do and we don't get done what we need to get done because we keep on talking about it. What you've got to do is get it going first, and then talk about it.

You will learn by the way we teach. So what they do is put memory in the minds of people so all they do is memorize and put it back on paper and give it back to the professor. What we've got to do is live our own stuff, which means what you've got to do is do it for yourself. Therefore you've got to do it. And if you do it and then you come back and reflect and talk about it and put it on paper, put it wherever you've got to put it so you can say it again. You've got to be able to tell your story, but you can't tell a story if you haven't enacted a story. You've got to do it. I know that doesn't set well with a lot of people.

It reminds me of 20 years ago when there were 60 people in the church and I said to them, "You know, I'm going to take down the cross." And they said, "You're crazy. You would never do it." I took it down and I got a jazz band and I got a lot of people to show up. And the people were crowding into my place because

BEST COPY AVAILABLE

what I did was, I said to them, "I'm not going to be a traditional church." And they said, "We wouldn't expect that from a black minister." And I said, "I'm not a black minister. I am a minister who is black who's going to chance the whole issue here and bring some soul into this church."

So we must be able to use the power of death and that means that we get to create life. Don't lock yourself in. These are exciting times. We can begin now, or we can just let it go.

WOMEN, WORK AND SUBSTANCE ABUSE

Lois Morris, M.A., C.A.C.

Daytop Village, Inc.
New York, NY

A comprehensive examination of the problem of chemical dependency among employed women that is solution-oriented must deal with three primary sets of data: 1) facts about women's chemical dependency; 2) facts about women's working lives; and 3) information about the relationship of women to employee assistance programs (EAPs).

Significantly, an examination of the three sets of data indicates that the profiles of women as workers, as substance abusers, and EAP consumers, differ substantially from those of men. This paper will examine the three sets of data indicated, thus exploring salient features of women's lives as workers, and as substance abusers, and the relationship of women to Employee Assistance Programs.

The basic purpose of the paper is to cull from facts concerning women's chemical dependency, their work lives, and their relationship to EAP programs directions for the development of prevention programs and effective new EAP models especially addressing the treatment needs of chemically dependent working women.

A final analysis/recommendations section of the paper will attempt to integrate information from the three areas considered to arrive at recommendations suggesting directions for development of effective employee assistance program services for women.

Women and Chemical Dependency

Salient facts concerning women and chemical dependency include the following:

1) The roots of the double standard taken towards women's chemical dependency are both ancient and still powerful today. In ancient Rome a man was legally permitted to starve or stone to death his wife if he smelled wine on her breath, since her drinking was considered a precursor to adultery. The Roman wife could not similarly punish her husband for his drunkenness.

2) The double standard taken towards women's substance abuse is still operative in the U.S. in the 1980's. This prejudicial attitude towards female substance abuse often seriously interferes with a woman's being able to admit that she is chemically dependent. Thus, it severely impedes the woman's ability to take effective action against a life-threatening problem.

3) The double standard adopted towards women's chemical dependency is probably reflected in the fact that chemically dependent women, unlike men, are very frequently abandoned by their spouses.

4) Substance abuse literature reports that women are especially vulnerable to the positive or negative influences of "significant others" in development and maintenance of or recovery from chemical dependency. Relevant literature, for example, states that:

* Women are, with very great frequency, introduced to drugs by a man--usually a spouse or boyfriend--who is often also involved in the woman's continuing drug use. Chemically dependent women receiving positive support for treatment from a husband or close male friend, however, have higher recovery rates than women who don't receive this support.

* Society's double standard evaluation of the chemically dependent woman encourages many families to deny the female family member's chemical dependency. Family denial reinforces the woman's personal denial of the problem. Because of the profound role that families can play in supporting or undermining recovery, a currently preferred confrontation strategy in working with chemically dependent women is to confront the woman about her substance abuse in the presence of family members.

* Chemically dependent women appear to experience considerable guilt concerning the impact of their addiction on their role as mothers and wives. Many express concern that their substance abuse will harm their husbands' reputation and social standing.

* A major Odyssey House study found that 44% of women in treatment in the program, at a certain period, were incest victims. Developmentally, significant others also appear to be powerfully associated with women's substance abuse.

* Recent alcoholism research indicates that daughters of alcoholic parents are at higher risk for chemical dependency than any other known group.

5) New York State Division of Substance Abuse Services data indicates that providing good health care services, including gynecological and obstetric care, is highly correlated with retaining chemically dependent

women in treatment. Child care programs also seem to significantly support recovery of chemically dependent women.

6) Although use of psychotropic drugs is consistently higher among women while men more often use alcohol to self-medicate for stress, drug taking habits of the young of both sexes, both in terms of the percentages using drugs and types of drugs taken, are becoming more similar.

7) Chemical dependency literature more often profiles chemically dependent women than men as suffering from secondary mental health diagnoses, especially anxiety neurosis and depression. The presumption of the more frequent or severe mental health problems of chemically dependent women has been called into question, however, by some studies calling for substance abuse researchers to be sensitive to stereotyped notions of masculine and feminine behavior biasing the observations, theories and theoretical perspectives of their studies. A greater societal readiness to perceive women generally as more mentally unstable may also partially account for the hypothesized greater mental health pathology of chemically dependent women.

8) Although considerable substance abuse literature portrays female addicts as having low self-esteem and a poor image of their sexuality and sexual attractiveness, it has not been conclusively established that these characteristics are more typical of chemically dependent women than men. These findings may be partly an artifact of the double standard taken towards female drug abuse. It seems clearly established, however, that substance abusing men and women share many important similarities. Many alcoholic men and women, for example, report distanced parent-child relationships, dependency problems, and a history of using alcohol to escape internal and external stress. Women, those chemical dependency is generally more harshly judged by society, may, not surprisingly, be more likely to experience guilt and depression concerning their substance abuse.

The Relationship of Women to Employee Assistance Programs

The following are salient facts concerning the relationship of working women to employee assistance programs (EAPs):

1) The Women's Drug Research Coordinating Project suggests that the process of addiction, definition of social productivity, and social roles and relationships generally differ for women and men. If this is so, women's relationships to employee assistance programs could be expected to differ, even significantly, from men's.

2) EAP literature suggests that many companies and supervisors hold female employees in generally low esteem, do not take them as seriously as male workers, and don't expect a similar level of performance from them. Women's relationship to employee assistance programs should be impacted by these attitudes.

3) EAP data consistently reports that a lower percentage of substance abusing female employees are reached by company and union employee assistance programs. Yet female employees represent both a large potential market as direct consumers for EAP services because of their substance abuse and other personal problems leading to work impairment. Working women also represent a large market for EAP services because of their children's substance abuse and the high proportion of women married to substance abusing men.

4) Some recent EAP literature suggests that there may be a generally stronger distrust of work organizations by female than male employees. This distrust may be associated with the demonstrated lower utilization by women of employee assistance programs.

5) EAP literature consistently cites greater reluctance by both male and female supervisors to confront female employees about generally impaired work performance or concerning suspected substance abuse. Reasons given by supervisors for this reluctance include women's greater sensitivity, tendency to take confrontation as an affront; tendency to use personal problems as an excuse for non-performance, and susceptibility to crying.

6) Survey data indicates that both male and female supervisors admit ignoring female job performance problems longer due to fear of the woman's reaction to being confronted. In line with this self-report data, men and female supervisors do, in fact, less often refer female than male employees to employee assistance programs.

7) A prime external factor associated with lower utilization by women of employee assistance programs, however, stems from women's different fit into work organizations. Women's generally lower job status and fewer fringe benefits, more frequent part-time and temporary job placement, and unemployment in organizations employing under 20 employees are associated with women workers' more limited access to health care plans and to employee assistance programs.

8) Employee Assistance Programs in the United States, although undergoing changes, are still male model programs. The greater number of employee assistance programs are administered by males, were designed by males for male clientele, and are more successful in outreach efforts to male than female employees.

9) The pervasive underemployment of American women seems to serve as an obstacle to employee assistance program casefinding among non-professional, non-management level women employees. Many women report being able to perform adequately on their jobs despite their addiction or alcoholism.

10) The structure of management positions does not seem to interface well, for either sex, with the employee assistance program model. Women who move out of lower status, low autonomy and closely supervised jobs, like men, appear to be at greater risk for substance abuse.

11) While employee assistance program literature indicates that absenteeism is a good indicator of both female and male occupational impairment below management level, this literature suggests that deterioration in personal appearance can be a particularly helpful cue to occupational impairment in women.

12) Chemical dependency literature suggests that specific stressful life events more often trigger women's than men's substance abuse.

13) Research findings indicate that female employees who do enter treatment through contact with an employee assistance program have almost as high a recovery rate as male employees referred through the employee assistance program.

Profile: Women as Workers

The Labor Department provides the following key facts about women workers in the United States in the 80's:

1) 47 million women , or 43% of all workers in the United States are women.

2) The average full-time woman worker earns 59% of the average male worker's earnings.

3) The majority of women work because of economic need. Two-thirds of all women in the labor force are single, widowed, divorced, separated, or have husbands earning less than $15,000. These women work because they must.

4) Women represent 63% of all adults below the poverty level.

5) The unemployment rate is lowest for adult white men and highest for young black women.

6) The average woman worker is as well educated as the average man; both have completed a median of 12.7 years of schooling.

7) The more education a woman has, the greater is the likelihood that she will seek employment.

8) Women with 4 or more years of college earn about the same income as men with 1 to 3 years of high school. Women high school graduates who are fully employed earn less than men who haven't completed elementary school.

9) 66% of all part-time workers are women.

10) Women are concentrated for the most part in low paying dead end jobs. 60% of all clerical work3ers are women versus 6% of all craft workers. Women constitute 62% of service workers but only 45% of professional and technical workers; women constitute 63% of retail sales workers but only 28% of non-farm managers and administrators.

11) The average woman workers is 34 years old and can expect to work for 18 additional years.

12) 70% of women 20 to 24 years old work. There is a strong national trend for labor force participation to be highest among younger women.

13) The influx of women workers into the labor force in the 1970's has resulted in nearly equal labor force participation rates for women by race.

14) Women account for 60% of the increase in the civilian labor force in the last decade.

Working Women and Families

1) Two-thirds of persons living below the poverty line are women. In 1983 more than one out of every three families maintained by a woman was poor as compared with one of 13 other families.

2) The median income for families headed by women was $15,080 in 1984. The comparable figure for families headed by men was $23,400.

3) The number of working mothers has increased more than tenfold since the period immediately preceding World War II while the number of working women has more than tripled.

4) 59% of all women with children under 18 years of age are in the labor force. 50% of mothers with preschool children work.

5) Women are maintaining an increasingly large proportion of all families--16% in 1982. A significant proportion of these families subsist at incomes below the poverty level.

6) 70% of poor black families are headed by women. 50% of poor Spanish families are headed by women. 39% of poor white families are headed by women.

7) Most employed women maintaining families have tended to remain in the generally low paying or less skilled jobs. Like most employed women, the largest proportion of those maintaining families were in administrative support jobs, including clerical work.

8) Characteristics of women workers who head families include higher unemployment, lower educational attainment, more dependent children, and lower earnings when compared with other labor force groups. These characteristics explain in part the high incidence of poverty in families maintained by women.

9) Most employed women maintaining families worked at full-time jobs in 1984--82%. Those aged 25 to 54 were more likely to be working full-time (85%) than either younger women (72%) or older women (75%).

The basic message of these Labor Department women's and family statistics is that more women work--that very large numbers of American women have very quickly entered the labor force.

A second important factor complementing the quickly increasing participation of American women in the labor force is the fact that more women have to work--because they live independently and must maintain themselves; because they need to supplement low family incomes; and often because they are the sole support of children.

A third important fact of American women's work life is that women who work earn considerably less--only slightly over half of what their male counterparts earn. This is true despite the fact that women, as a group, are as well educated as men. Women's degrees, however, translate into very much less income than do men's. Women college graduates earn what male high school dropouts earn. Women with high school diplomas earn less than male dropouts from elementary school.

Significantly, too, women generally have less seniority and less job security than men. Women are historically unemployed at higher rates and are less able to collect unemployment compensation than men.

Women are under-represented as union members and over-represented as part-time employees. Consequently, women have less access to employment benefit packages and to job protections.

The bottom line of Labor Department statistics on women and work are the salaries paid to women and the kinds of jobs women are trained for, conditioned to accept, and hired to fill. Women are still concentrated in dead end low paying jobs. This is the basic fact of women's employment.

The other, very significant aspect of Labor Department family statistics for working women is their clear delineation of a rapid and sharp increase in the number of families maintained and supported by women--a rise not matched by an increase in women's earnings.

Trends Concerning Women and Work

Trends concerning women's status in the labor market present a complex and contradictory picture. There are many indications that things are and will get better for working women, but there are also strong new negative trends.

Positive Trends. Positive trends and gains for women workers include:

* An increase in women's overall employment despite downward trends in the U.S. economy;

* Penetration by a certain percentage of women into occupations formerly almost completely closed to women, especially in high paid professions and blue collar jobs;

* Educational advancements by women, at least at the upper ends of the educational scale; and

* Legislation attempting to guarantee women equal opportunity in employment.

Downward Trends. The following are four major trends inhibiting the quality of women's status as workers and the gains in employment that women have recently been attempting to make.

* The increasing feminization of poverty, i.e. an accelerating trend through which women and their dependents are overwhelmingly becoming the poor in the United States. The major factor behind the upsurge in female poverty, however, appears to be the phenomenal increase in women raising families alone. There were 8.5 million women raising families alone in 1979--an increase of 30% in just nine years;

* Cutbacks in publicly funded employment and training programs;

* Weakening of equal opportunity and affirmative action mandates that remove incentives to hire women;

* Automation of office work that threatens to eliminate jobs held by the majority of women office workers.

The U.S. Department of Labor's assessment of major obstacles facing working women include the problems of 1) access to the full range of existing jobs; 2) women employee's low pay rates; 3) stress because of women's dual roles at home and at work; and 4) women worker's need for various forms of counseling, family support systems, and flexible work hours.

Analysis and Recommendations

The following recommendations for adoption of and changes in employee assistance programs are made with the end in view of 1) increasing the number of referrals to company any not work equally well for both sexes. Thus, if industry does not wish (and is not structured) to maximize a high level of functioning from female labor, it is doubtful that a work impairment supervisory intervention mode will be an optimal tool for casefinding chemically dependent women workers. If female workers are more valued as a source of cheap labor, or as a labor underclass, than as workers functioning up to capacity, chemically dependent women workers will be able to easily hide thintersect with women's underutilization of employee assistance programs is in the design of the programs. The currently most favored EAP design--the work impairment/supervisory intervention model--appears, for some very basic reasons, to have limited effectiveness in reaching chemically dependent and otherwise occupationally impaired women. If, as the Women's Drug Research Coordinating Project suggests, definitions of social productivity are quite different for women and men, this model may not work equally well for both sexes. Thus, if industry does not wish (and is not structured) to maximize a high level of functioning from female labor, it is doubtful that a work impairment supervisory intervention mode will be an optimal tool for casefinding chemically dependent women workers. If female workers are more valued as a source of cheap labor, or as a labor underclass, than as workers functioning up to capacity, chemically dependent women workers will be able to easily hide their occupational impairment under cover of their under-employment. This is, in fact, what research indicates often happens. Many women workers report being able to perform adequately for long periods of their jobs despite their chemical dependency.

To solve the problem of women employees and the supervisory intervention EAP model raises both many complexities and possibilities.

First, pervasive female under-employment, which stands as a significant obstacles to usefulness of the impaired worker performance EAP model, can be addressed by government and individual businesses on an affirmative action, employee placement, and job design level. Addressing the problem of female under-employment head-on is a grassroots approach to the related problem of women's fit into employee assistance programs.

Second, various modifications to the traditional supervisory intervention/impaired work performance model should be considered. The modifications can be basic structural changes or small changes such as use of symptoms and other criteria in addition to work performance deterioration as a signal to supervisors of a possibly troubled employee.

Finally, new models, radically different from the supervisory intervention/work performance EAP model, should be considered in the attempt to reach more occupationally impaired women.

The supervisory intervention employee assistance program model appears to have generals limited usefulness with male and female managers and executives. Women who are able to move out of lower status, low autonomy, closely supervised jobs appear, like men who attain higher level positions, to be at greater risk for substance abuse. The supervisory intervention model appears to be rather ineffective in casefinding among this population. Former male and female chemically dependent executives both report having been able to rearrange their work schedules around their drug dependence or alcoholism so that obvious signs of work impairment, such as absenteeism and lateness, did not surface.

Although women managers, like men, commonly gain autonomy, which can camouflage chemical dependency, from managerial job titles, women managers' chemical dependency appears to be doubly hidden due to the fact that even as managers they are often underemployed.

The EAP model based on supervisory intervention due to signs of deteriorating work performance would thus appear to be a problematic tool for reaching chemically dependent female managers and professionals. To compound the problems of EAP outreach to the chemically dependent woman manager, the

peer intervention model, sometimes used alternatively to the supervisory intervention model, is more difficult to utilize with women managers than with men because networking systems for women managers are much rarer, and less developed, than those for men.

Present data strongly suggest that the supervisory intervention/work performance EAP model is an inappropriate or ineffective tool for assisting chemically dependent women managers. Successful adaptation of the peer intervention model to this population appears to be a more viable outreach strategy. Successfully adapting the peer intervention strategy to women managers will require management and unions to lay a foundation leading to stronger networking among women in higher level business positions.

Women's greater participation in the nation's health care system suggests that if employee assistance programs are adapted to meet women employees' needs, they will be successful in reaching this target population. Although EAP program designers and administrators may have to deal for some time with female reluctance to admit substance abuse because of the greater social stigma placed on women for this behavior, these double standard referral losses should be balanced by gains associated with women's generally greater willingness to be open about health care needs and their willingness to accept help from others.

Since family members and significant others have been shown to play a very large role in women's development and maintenance of chemical dependency, both strategies to bring women into the EAP program and treatment strategies for the female EAP client should contain a strong focus on family and significant others. Family members and significant others should be engaged in the women's treatment, wherever this is feasible, and not contraindicated clinically.

Women's extensive participation in the nation's health care system suggests that an effective location for employee assistance programs seeking greater outreach to female clients is within a medical unit structure. Seminars on health topics of particular interest to women can serve as excellent vehicles from which to obliquely approach the subject of women's substance abuse. Health topic seminars serving as vehicles to introduce the topic of chemical dependency to women workers could include:

P.M.S. Blues
Women and Stress
The 24-Hour Day: Wife, Worker and Mother
Vocational Planning and Counseling
Adolescents and Drugs
Marriage Maintenance
Return to a Career after Raising a Child
The Middle of Life: New Vistas
Weight Reduction
Money Management
Exercise and Health Care
Nutrition
Singles' Lifestyle
Single Parenting
Building a Career
Job Advancement
Women's Networking
Money Management
Coping with Loss

Because of women's generally stronger home and people orientation, employee assistance programs that wish to be successful in attracting chemically dependent and other occupationally impaired women need to become well established in the workplace in a quite personal way. The employee assistance program should gain a reputation in the workplace as 1) a place to go to: a place which is accessible, special, warm, caring, but confidential; and 2) a person to go to: the EAP manager or counselor needs to become established as a well-known, trusted, and liked person.

Research in the EAP field has demonstrated that presence of a woman on staff is a major factor in increasing program outreach to women. The advantages of the identification factor are obvious. Additionally, considerable research indicates that many chemically dependent women have experienced child abuse and other difficulties in sexual or sensitive areas that may be easier to broach with a woman counselor. Staffing more employee assistance programs with women is likely to provide impetus for more female self-referrals to the program.

Employee assistance programs that provide important and needed services to women, in addition to traditional alcoholism and drug dependency counseling, should achieve higher utilization rates by chemically dependent and other occupationally impaired women. Counseling services which the EAP can provide for women employees include:

* Career and vocational counseling including counseling concerning promotional opportunities and possibilities within the work site and the training or background required to be a candidate for specific positions.

* Financial counseling.

* Assistance for women needing to coordinate work hours with child care and other family responsibilities.

* Legal referral service.

* Exercise classes.

* Weight reduction and nutritional counseling and planning.

Employee assistance programs that wish to increase outreach to chemically dependent and other occupationally impaired workers should be able to reach this goal by addressing some of the central problems which women worker's face, including the considerable gap between women's educational backgrounds and their job status and salaries. The employee assistance program can do this by providing ongoing vocational and career counseling and/or seminars on these topics. The threat to job security that automation poses to the very large proportion of women who are clerical workers, for example, can be reduced by the employee assistance program providing seminars on the topics, referrals for re-training, and sponsorship of training in latest office technology. These "extra" EAP services can also include counseling to help women effectively mobilize current training and experience to attain promotions or higher paid work within their present work organization. The "EAP extras" can justify their expense by assisting companies gain greater trust of women employees (a troublespot mentioned by EAP literature), lead to greater numbers of women referred to the EAP program and also provide a much needed service for women employees.

A promising suggestion of Harrison Trice's recent work with women and EAP's is the idea that EAP administrators and researchers can take advantage of the fact that women workers are highly concentrated in a few "traditional occupations." EAP developers can work with the unions and trade associations associated with these "women majority" industries to reach chemically dependent and other occupationally impaired female employees.

Media promotion of EAP's can easily be changes so that it's more likely to be attractive to a female audience. Such simple changes as representing women on EAP posters and advertising and using the feminine as well as masculine pronouns, would be a first step toward doing this. Designing EAP-sponsored seminars of special interest to women employees would be an intermediate step.

Due to the very demanding household and childcare responsibilities which many working women hold, EAP's need to carefully consider scheduling time for EAP outreach activities and treatment for women personnel. Scheduling these activities and treatment itself during the lunch hours or during work hours release time may prove more feasible than scheduling them after the work day ends.

Employee assistance programs need to provide ongoing training for supervisors which addresses the needs of chemically dependent women employees and which also addresses problems supervisors come to experience in confronting and referring women to employee assistance programs.

NATIONAL FEDERATION OF PARENTS

Shirley Colletti

National Federation of Parents

The National Federation of Parents was organized in May of 1980. We opened our offices in Silver Spring, Maryland in February of 1981. We are in communication with over 8,000 parent groups throughout America and network with many national organizations such as the Parent Teachers Association (PTA) and National Association of Broadcasters.

We encourage the parent groups to involve themselves in their children's circle of friends and their parents. As your child begins to become more independent, we encourage our parents to become more involved. The parent movement is really a type of empowerment model --the same model many of our parents and grandparents practiced.

TCs can play an important role in assisting the development of the patent movement. We must use all of the expertise that we have gained over the years to help the parent group that has formed or may be forming in our communities. True prevention of drug and alcohol abuse must start in the home. When many of us were developing treatment programs 15 years ago, we realized the need for parents to involve themselves in the drug prevention effort. Unfortunately, a great deal of denial and fright existed in them,and we were not successful in recruiting parents into our fight.

Today, however, we are on a new frontier. We have parents, schools and communities looking at the community based treatment programs, such as therapeutic communities, for leadership in areas of drug and alcohol education. I say leadership, but not ownership, because if the parent movement is to thrive, we must allow and encourage the ownership and, yes, the work to stay with the parents. For too long we have seen families look to us to fix the child, and you know and I know this doesn't work.

The fix the child syndrome has encouraged a proliferation of miracle cure 28-day programs across the country. It is my belief that many of these programs are duping and misleading parents into believing that their child will be fixed if we will just leave the youngster for as long as the insurance holds out. What happens then? You guessed it.

The National Federation of Parents is rapidly becoming viewed as a potent force interfacing with Congress and legislatures around the country. I believe that most of our programs have had to spend so much energy on funding issues and just plain survival that the important legislation for change has not been dealt with. The NFP is joining with other constituency groups to educate legislators and decision-makers, and we are beginning to see some achievements in state legislatures and in Congress.

The parent movement is in its infancy and is still having growing pains as you all did years ago. Join in the movement because, after all, aren't most of you parents?

THE PARENTS' ASSOCIATION IN AUSTRALIA

Ian R. Permezel

Odyssey House
Victoria, Australia

Therapeutic communities in Australia tend to follow the American model and our therapeutic community is based on the Odyssey program. The Odyssey program has been developed over an 18-year period through the thought and the effort of the American psychiatrist, Dr. Judianne Densen-Gerber. It is now established in five American states, in two Australian states and in the two islands of New Zealand.

A parents' association is attached to each Odyssey program, and these associations are linked but are not in any way part of each treatment program.

In Australia, the two Odyssey Houses have an overall resident population of 300 persons. These two houses are 500 miles apart and each parents' association has a slightly different name and a slightly different mix of people.

I will talk about the Melbourne Odyssey House and its parents' association. First, an overview of the parents' association.

In Melbourne, this association is almost six years old and it has a membership of approximately 150 parents and special friends. About 100 people regularly attend the monthly meetings.

The association is a properly constituted group. It holds annual general meetings, it elects office bearers and it makes presentations of accounts. The main aim of the association is to give support to the parents who have sons or daughters in the therapeutic community.

The leadership of the association has been good, capable and caring. The membership is open to all parents, relatives and friends, and the payment of a membership subscription is quite voluntary.

The parents' associations' source of funds is mainly from the membership subscriptions plus some fundraising activities, firstly to provide a Christmas luncheon for the residents of Odyssey House and, secondly, to purchase some special pieces of equipment for the House as the need arises.

The meetings of the association are properly conducted and comprise three parts, each with a district education component.

a) There is always a guest speaker on a therapeutic community related subject such as treatment aspects, medical topics, legal concerns, etc.

b) Speakers from the therapeutic community, usually senior residents, explain the nature of the therapeutic community and the various stages or levels which form the structure of that community. These speakers also make themselves available to talk to the parents after the meeting and are always engaged in a vigorous question and answer session.

c) The final part of the meeting usually comprises socialization and the sharing of experiences in an informal and unstructured way.

In a recent survey of parents, no one wished to change the simple format of the meetings as they found it a satisfactory way to acquire knowledge of the therapeutic community and to socialize.

Between meetings of the association, members are encouraged to contact a small group of experienced parents who are available to discuss any personal problems relating to their sons or daughters in residence at Odyssey House.

The parents of the residents are also encouraged to keep contact with the staff of the therapeutic community and, at the appropriate time, to make contact with their son or daughter. But this contacting process is essentially a function of the therapeutic community and no the parents' association.

The Melbourne therapeutic community comprises between 150 and 170 people who are in long-term residents. The residents comprise adults, adolescents and drug-affected parents with their own young children. The age range of the residents in treatment is from 13 years old to 35 years old, the average age being 24. There are three males to every female.

The residents of our therapeutic community are made up of a broad cross-section of the local community.

a) There are varying levels of economic status represented from the wealthy to the middle class to the poor.

b) There is a range of people from various social strata.

c) There are many ethnic backgrounds represented spanning English, Italian, Greek, various Middle European, Asian and, of course, Australian.

d) There are many variations of educational achievement from primary levels to secondary and tertiary levels.

It is interesting to compare this profile of the resident population with the membership of the parents' association. How does it match? It is obvious from the above that the age range of the parents who come to the meeting will be very wide, from the early thirties to the late sixties, and this age range creates real generation gaps and some tensions. As you would expect, the parents of sons outnumber the parents of daughters on a three-to-one basis.

It might be expected that the same broad cross-section of the community which is represented among the residents is also represented among the parents. But this is not so. The parents who attend meetings of the association seem to comprise the middle ground of the economic scale, the social scale and the education scale. Those parents who are at the ends of the spectrum rarely seem to attend.

It appears that the wealthy and those with high social status are not anxious to be identified in a public way with drug addiction, and those who are educated above the average seem to have the view that they can cope on their own.

Those parents who are at the lower end of the wealth, education and social scale are often too poor to come to meetings, are too uncertain of themselves in a social setting and don't feel articulate enough to mix with those who have been better educated.

In those cases where the parents are the first generation in Australia and are non-English speaking, then their attendance at meetings is almost impossible unless accompanied by one of their children who then acts as an interpreter, often an embarrassing situation for them all.

The above reasons for non-attending result in a different mix of parents at the association meetings. The mix is also made different by those parents who do not attend for other reasons. There are those who do not attend because they really don't care. Often their son or daughter has caused them enough grief and trauma and they have had enough of the relationship. Then there are those parents who are alcohol or drug-addicted themselves.

Finally, there are some families where physical, sexual and emotional abuse by one or both parents has had a major impact on the lives of the family members, and those parents are less likely to attend. Where family members do attend in this category, they often dissociate themselves from the past.

As there are many reasons why parents do not attend the parents' association, there are also many reasons why parents do. In our recent survey of parents, the most common reason given for attending meetings is to gain support from people who have been, and are, in a like position. There is a relating to the same problems, a sharing of the same burdens, a coming to terms with the feelings of guilt. These parents are seeking friendship, understanding, are moving from "heartache to optimism." They seek a chance to talk.

Most of the parents have learned hard life lessons with a drug-addicted person in the house. They have stumbled on the pot, the needles, the powders. They have seen the changes which take place in the personalities of their children. They have watched the irregular sleep patterns, the missed meals, the total irresponsibility within the family, the large debts and the thefts, the police at the door and the courts.

And they want to tell the stories to one another about the confusion, the talking, the pleading, the contact with doctors and hospitals and health care agencies, the merry-go-round of well-meaning people, their own ill-equipped efforts, and the mess they made of their attempts to help.

Positive changes take place as parents learn about new ways to cope with drug-affected people. Looking back now, most parents say they would get help sooner, they would bring things to a head, they would say "no" to demands and, as one mother has said, "I would have much less respect for my daughter's so-called freedoms."

Of course, many parents are in a dilemma about the action they would take in the future. As one father said, "I would give less support to my son knowing what I know now, but the final decision would be based on keeping my child alive." A mother said, "I know what I should do, but I am a mother first and a logical person second."

As well as seeking support from one another, what else are these parents looking for? They want help when their sons or daughters split the therapeutic community. They want the courage and the confidence and the knowledge to be able to say, "Go back."

Nearly all the parents recognize that they have their own "coping with life" difficulties and that outside professional counseling would help. They would like the parents' association to help arrange that counseling. They would also like to help parents whose sons or daughters are abusing drugs, but who haven't yet found the therapeutic community. Most parents would be prepared to talk to those parents (but not to counsel) on a one-for-one basis. This is the beginning of a bridging process between the parents' association and the wider community.

And many parents would like to be much closer to the therapeutic community, to be more involved, to sit in on group sessions, to be part of the therapy process. The question is, "Is that closer relationship possible, and is it realistic?"

THE FAMILY ASSOCIATION IN AUSTRALIA: CLINICAL ASPECTS

Joe Lamberti

Odyssey House
Melbourne, Australia

The purpose of having this paper in two parts is to accentuate the fact that in our mind there are definitely two aspects to the relationship between the therapeutic community and its members in treatment and the Family Associations connected to that program. The first section by Mr. Permezel described the constructive and productive aspects of a Parents and Supporters interaction with the therapeutic community are both true and necessary. However, we did not want to confuse that with the very sensitive treatment issues involved in some of the more complex inter-family relationships.

In 1975, The Odyssey House Program in five different states in America conducted a research program focusing on the causative factors of drug addiction. At that time our figures showed that 70% of our resident population in those five programs had been victims of some form of overt child abuse, including psychological abuse, physical abuse or sexual abuse. In fact 44% of the women in the study were shown to be sexually traumatized within the family in their prepubescent years. These figures have been consistent over the years and a recent survey in our programs in Sydney and Melbourne, Australia show very close correlation with the studies conducted in 1975 in America.

Secondly, I would like to point out that it has been our observation that there are families who may not be overtly abusive but tend to be possessive, infantalizing and have a vested interest in keeping a child dependent. It is these types of families who tend to be the biggest saboteurs of a person's ability to complete the therapeutic community process.

It is for these reasons that we strongly believe that there needs to be, in some instances, an arms length relationship with clear separation between the treatment or therapeutic bonds between the residents and the staff and the program's relationship with the parents.

I would like to make clear at this point that we are not against family therapy and, in fact, recognize the necessity when appropriate for ongoing intense family therapy in order to treat the whole person and his or her environment in order to prevent continued drug abuse after the therapeutic community process is completed. It has been our experience in addressing the problem of drug related child abuse that there is a common pattern followed by the abused child in which they believe that they themselves are at fault for the abuse and that if they would be good girls and boys, mummy and daddy would not have to act out against them in such a way. This creates a syndrome in latter years where the abused child repeatedly returns to the family seeking positive recognition only to be met with continued abuse. Thus a cycle is developed, the more the abuse, the more the child needs to seek positive attention.

It is in cases like these that the therapeutic community must be able to allow a child to be an individual and grow up to be a responsible independent adult, developing appropriate distance and a respectful relationship with their family, without total pathological dependence. The therapeutic community must be careful not to openly go against the family, as this only results in panic and the person in treatment retreating completely away from the therapeutic community and following their instinctive loyalties to their family.

One example of this is the immigrant family where both parents were factory workers, the father working the nightshift and the mother working the dayshift. Due to language problems and an inability to negotiate the Australian school system, they "overlooked" entering their 6 year old son in primary school. This created a situation where the boy was left home unattended, with the exception of his father whose sleep was so important in order for him to continue his nightshift position. The way the family chose to problem solve this situation was to tie the boy with a length of rope to his father's leg for eight hours during the day, with only a bottle of milk and a loaf of bread to keep him occupied. If at any time he would go beyond the boundaries of the rope he was met with a rage reaction from his sleeping father.

In order for this young man to work through the love/hate relationship that exists with his family, he must first individuate and develop a bond with the program staff in which he can go through his ambivalent emotions first and then later develop the relationships with his family perhaps through family therapy.

The other example would be a typical incest family secret phenomenon. We have one case in our Australian program where the incest perpetrator in his attempt to maintain the family secret and loyalty relationship between him and his daughter (who is in the Odyssey House Program) continued to shower the program with large donations and exaggerated promises for the future. If the program was to actively embrace this family during the initial stages of the girl's treatment it would create a situation in which it would be almost impossible for the incest victim to feel free enough and safe enough to confide in the program staff with such accusations against the family.

It is in these kinds of situations that it is extremely important to be sure not to create a conflict of loyalty among the treatment staff and the people in their care. We must also be extremely careful not to create a

sense of betrayal on the part of the person in the program. It is important that the people in the therapeutic community feel that the TC is their territory, their experience and their private relationship with the people who they open up their most inner secrets to. It must be in their control who and when other people receive the information that they divulge in the course of their therapy, including, and sometimes in particular, immediate family.

There seems to be a general naive belief that in order to complete therapy you must keep the family together at any cost. I can only emphasize that is situations where there is a pathological relationship, if at all, from that point. When you have a destructive family system you must allow the person in treatment to come to terms with it and cope through the surrogate family support of the therapeutic community, not to replace the blood family with the therapeutic community, but to allow the TC to become an additional family so that if the person in treatment chooses to be independent from their blood family, they have an avenue to do so. And it is our obligation to support them in this endeavor and impress upon them that it is their right as an individual human being.

THE CHALLENGE OF GROWTH AND CHANGE

Michael Maloney
Daytop Village Family Association,
New York, NY

Back in 1966, the Daytop Village Family Association came into being. At first that small group of parents met whenever and wherever they could on Staten Island. With the acquisition of the first outreach storefront in 1967, parents began meeting on a regular basis on the lower east side of New York. Initially, family members assembled as a moral support to their residents, but it soon became apparent that these family members had feelings of their own to deal with--guilt, anger, fear, confusion, irresponsible love, etc. The question became, "What can be done for the parents of drug abusers? Hoe are they helped to grow and change? How does their growth and change, or lack of it, affect their loved one in treatment?" The answer--a family association!

A new member of the association goes through a very structured process of learning what the association is all about. In orientation, the parent has the opportunity to talk about fears, guilt, confusion, etc. Quite clearly, this is an educational stage. The education and learning continues from orientation to pre-encounter, to concept group and finally to encounter groups where they get the opportunity to deal with their feelings--to grow and change.

Over the years, almost 20 at this point in time, this procedure has helped thousands of parents and family members. Almost 20 years is a long time. The time span itself is a problem. The Daytop Village Family Association must be alert. Alert to what? For one thing, the parents of the 80's are very different from the parents of the 60's. Today's parents are the adolescents of the 60's. Their thoughts, ideas, and philosophies are very different.

We find many of today's parents are or have been involved with drugs themselves and see no problem with using drugs. What is our challenge? The challenge is the changing times and our ability to change with time--our ability to adjust our ways of getting through to the parents we are dealing with today.

How do we do this? We change the structure of our parent groups, i.e., we always believed that husbands and wives should not be in the same encounter group. Now we say, maybe they should!

We have adjusted our Ambulatory Treatment Centers so that the parent of an outreach member must attend parent groups at the Outreach Center, allowing the staff at the Outreach Center to work closely with those parents who have children attending on an ambulatory basis.

Our midtown headquarters is geared for the parents who have residents in a 24 hour therapeutic community setting. This gives us the ability to help these parents on a more personal level because they are different from the parent of an outreach member. We are currently in the process of developing groups for the parents of our adolescent residents. Their situation is also a unique one.

Another challenge that looms is what do we do for the parent who has been attending groups for three, four, five years? How do we motivate and stimulate interest? At Daytop, we have recently developed "specialized groups." Husbands and wives; a group for men only; women only; prejudice groups; groups for family members who have elderly ailing parents; members who have recently lost a parent. These groups are proving exciting sources for growth and change.

For the first time, this year, 1985, the Association reached out to touch the entire family of a drug abuses. We developed a program for Siblings Of Drug Abusers (S.O.D.A.). Thirty-seven youngsters attended. The sessions were not run as encounter groups, but rather a setting for them to express their feelings about their brothers or sisters in treatment; the therapeutic community--what it is and why. The three sessions were conducted by a Daytop graduate and two parent group leaders. Was it successful? We think so. Thirty-five children returned to attend all three sessions.

While the siblings were attending their meeting, their parents were also meeting as a group; the purpose here was to share ideas, thoughts and feelings. We encouraged the parents not to force their children to return to any one session; force would do more harm than good. The parents were given only general feedback since the emphasis was on strict confidentiality. Communication between parent and sibling was the biggest problem. Our eventual goal is to move this program into the ambulatory treatment centers.

Along with the changing times, the structure of the Family Association--the table of organization--has changed. The entire board is made up of 21 members--seven officers, seven chairpeople (one representative each from the seven outreach centers) and seven directors. In 1983, the entire committee structure was streamlined from 16 committees to 7 committees, with each of the committees under the aegis of a vice president.

By tightening up, we have strengthened the ability to govern, communicate and create new innovative structures. With the help of staff members, we support the agency to our fullest potential.

The challenge is always there! Since we are the recipients of those who came before us, we must be the guardians for those who come after us!

THE YOUNG WOMENS' GROUP

Leslie Anne Tarbell

Daytop Village
New York, NY

Approximately five years ago Daytop Village's Family Association began separate support groups for wives, girlfriends and daughters of residents in TC treatment. It was an effort to provide these women with a forum that warranted separate attention. What began five years ago as one group for eight women has now grown to a program servicing forty women. The adoption of our Young Womens' Group Program into the mainstream of our treatment program heralds the advancement of these women to primary client status, as opposed to their initial position as secondary clients within the Family Association.

One of the many reasons for this development is the changing profile of the woman client that approaches us for help and our subsequent adjustments in clinical focus and goals in response to this movement.

Although 47% of the women have a substance abuse problem of their own--they have used drugs at some point in their lives and/or been involved with a substance abusing male--these women are not dysfunctional, but can be considered as being impaired by substance abuse or in some cases self-medicating. These women have welcomed or brought into the fold other young women who are working, single, married, divorced and many who have children and are seeking supportive treatment.

The hardship faced by all of these women is a serious social problem. We are servicing women who feel victimized, and this manifests itself in a variety of physical and emotional problems that include drug abuse. For these women their involvement with substance abuse, a substance abusing male, unhealthy and destructive relationships or behavior patterns is a reflection of or an escape from depression, fatigue, guilt, low self-esteem and lack of control.

The most common concern among the Young Womens' group program members, no matter what their background, is the fear, anger and stress associated with the belief that they lack the power to change and improve their circumstances. This is a women's program in every sense of the word. It is run by women, for women, and specifically addresses the concerns of women in today's society.

The majority of working women we encounter have been facing discriminatory barriers to employment or advancement, were steered into lower paying jobs, have been harassed or outnumbered in male domains, are rooted in dead-end jobs and educated from childhood to have lower expectations. This negative aspect of the woman's work situation is critical when they must support themselves and their children and, as a result, feel obligated to withstand mistreatment in order to survive.

Although we can view our current group members as basically different from the original group in relation to certain behaviors and historical aspects, the clinical issues remain essentially the same. The clinical profiles and problems presented are more similar than different.

The clinical issues addressed in these groups share a common denominator that crosses all backgrounds and lifestyles. They meet in these groups because they want and need help in coping with harsh economic and social realities and, in many cases, dysfunctional family systems or the additional complications of substance abuse.

As a result of my prior negative lifestyle, and graduation from the Daytop program, the women in the group are able to better identify with me as their group leader on various levels:

1) *As a woman.* There is an intimacy that is shared which develops the trust and encouragement that they need as group members.

2) *As a resident.* To provide them with a more accurate account of the therapeutic procedures during residency and the expectations upon completion.

3) *As a role model.* To support their own sense of accomplishment by providing the consistent example of a positive lifestyle.

During my term as a group leader in the Young Womens' group, I have seen women come into the group unemployed and go on to get jobs. We have seen women with little or no education go back to school. We have seen women who depended on unhealthy relationships go on to become self-sufficient. We have seen women who have had little ability to express their feelings openly share their innermost fears, articulate their emotional needs and develop a positive lifestyle.

The Young Womens' group has grown since its inception into a program that is servicing women in genuine need. The women have made dramatic and positive changes as a result of their group participation.

In summation, the Young Womens' Group is meeting the needs of its participants, and by developing this program Daytop is providing support not only to the resident with the drug abuse problem, but also to the family whose lives they so deeply affect.

I would like to thank Liz Gardner and Gina Ingbar for their assistance.

WHOLISTIC COUNSELING

Individual Family Relationships Substance Abuse Herbs

HERBAL TEA BLENDS INFORMATION SHEET

DETOX BREW — This blend contains comfrey root, mullein, spearmint, rose hips, orange peel and golden seal.

Detox Brew has helped many people get off drugs the natural way. It is an aid to detoxification and is a tonic for the respiratory system, especially for colds.

RELAXO BREW — This blend contains valerian, spearmint and chamomile.

Relaxo Brew is a natural herbal tranquilizer. It is an aid for relaxation and a tonic for the nervous system. Relaxo Brew also helps to settle the stomach.

ENERGY MINT — This blend contains peppermint, gotu kola, damiana, red clover, red raspberry leaf and eleuthero ginseng.

Energy Mint is a mild herbal stimulant and energizer. It is a tasty substitute for coffee and contains no caffeine.

NUTRA TEA — This blend contains lemon grass, alfalfa, dandelion root, red clover, comfrey and orange peel.

Nutra Tea is rich in vitamins and minerals with a delightful lemony taste. Alcoholics have used this blend to strengthen the liver.

BIOTIC BREW — This blend contains spearmint, dandelion root, Oregon grape root, red clover, chapparal, buckthorn and burdock.

Biotic Brew is a potent blood purifier and cleanser. It brings oxygen to the tissues and helps to eliminate damaged cells from the system.

MOTHER'S TEA — This blend contains spearmint, red raspberry leaves and red clover.

Mother's Tea is used in pregnancy to alleviate nausea and provides natural sources of iron.

Herbal tea blends are tasty alternative beverages with little potential for abuse. Herbs contain vitamins and minerals essential for good health. Herbs can serve as helpful aids but cannot substitute for appropriate medical or psychological treatment.

THE PARENTING PROGRAM AT WALDEN HOUSE

Ethan Nebelkopf, M.A.

Walden House, Inc.
San Francisco, California

Substance abuse is not an isolated problem. It occurs in the context of a family system and family systems occur in the context of society as a whole. There is substantial evidence of the importance of the family in the genesis, maintenance and alleviation of drug abuse (Stanton, Todd, et.al, 1982).

Addicts who are married are deeply involved in at least two intimate interpersonal systems, their marriage and their family of origin. A systems approach to drug use recognizes that the addict as "identified patient" represents a symptom of a dysfunctional family process.

When a member of a family uses alcohol or drugs, parenting suffers, and children are high risk for drug problems. Addict families exhibit a high frequency of multi-generational chemical dependency, experience a preponderance of death and separation themes, and sometimes sabotage treatment efforts. Family therapy has positive implications for prevention because more people are involved in treatment, family members who otherwise would not be accessible to treatment.

THE FAMILY CONCEPT AT WALDEN HOUSE

Walden House is a publicly supported non-profit residential chemical dependency treatment program in San Francisco, housing 135 residents from all walks of life, ethnic groups and socioeconomic backgrounds. It is an 18 month program consisting of a series of phases from Orientation through Re-entry to Aftercare, based on the therapeutic community (T.C.) model. The philosophy at Walden House emphasizes self-help, so that each client learns to take responsibility for his or her behavior. Clients are treated like human beings with potential for growth and change.

The therapeutic community is a highly structured and well-supervised program designed to deal with the behavioral and emotional issues of drug abusers. The staff at Walden House is a balanced mixture of professionals and ex-addict counselors working closely together. The therapeutic community operates on a "family" concept. Residents relate to one another as brothers and sisters. In the daily process of living, working and growing together, residents learn to trust others and develop positive feelings of self-esteem.

THE PARENTING PROGRAM

The Parenting Program at Walden House was designed to help residents who are parents to improve their family relationships and parenting skills. Each prospective participant in the Parenting Program undergoes an initial intake evaluation session to elicit relevant family background material, from which a treatment plan is developed. Usually the spouse and child are not residents at the same time as the "identified patient" and are living in the community.

These activities include: individual and family counseling by professional family therapists, group therapy, a series of educational workshops, a couple's group, psychological evaluations of children, home visits, multiple family groups and field trips. Family counseling may be done with the whole family, the client and his/her child, or the client and spouse. Occasionally the spouse is seen for individual sessions, depending upon the needs of the family as determined in the initial evaluation.

For newer residents, the educational workshops focus on nutrition, relaxation and concepts of child development as well as teaching specific positive parenting skills. Group discussion and experiential exercises are utilized to help clients understand the dynamics of the family and the roles they play in their own families. Nutritional information is provided to parents, particularly the effects of diet on children's behavior. Relaxation exercises derived from yoga and herbal teas conducive to relaxation are presented in these workshops (Nebelkopf, 1981).

The group therapy sessions focus on the emotional and psychological aspects of relationships and family life, with the goals of improving the client's self-awareness and relationships within his or her family.

In addition, supervised field trips and social activities for parents, their spouses and children are offered on a monthly basis. In the past, field trips have included picnics, baseball games, museums and amusement parks with the purposes of observing and giving feedback to parents as they actually relate to their children, as well as teaching them positive aspects of re-socialization as a family.

GOALS AND OBJECTIVES

The goals of the Walden House Parenting Program are as follows: to strengthen family relationships and improve the parenting skills of residents who are parents, to prevent drug abuse among the children of residents through individual/family counseling and education, and to help re-integrate families of residents through early intervention, education and counseling.

The specific objectives of the Parenting Program are as follows: residents will receive individual and/or family counseling on a weekly basis to improve family relationships and problem-solving skills, residents will attend a weekly Parenting Group to improve their communications skills and self-esteem as parents, residents and family members will participate in a field trip or social event each month to learn positive family re-socialization skills, residents will attend a weekly Parenting Educational Workshop to improve their parenting skills and learn relevant concepts of child development, and new residents will undergo an intake evaluation process each month to determine their participation in the Parenting Program.

All residents of Walden House are eligible to participate in the Parenting Program, including those clients who are in the Aftercare phase of treatment. The Parenting Program has been singularly successful in helping clients of Walden House to re-build the integrity of their families, particularly during the Pre-re-entry phase of treatment.

GETTING FAMILIES INVOLVED

As part of the Family Services Program at Walden House is the Parents Association (The Walden Society), a support group for relatives and friends of residents. The Parents Association meets once a month for a community meeting and peer therapy and support group. It is an arena in which family members can deal with their own feelings and struggles within the family unit and learn how to provide positive support for the addict in treatment.

A mother of one of the residents at Walden House and member of the Parents Association feels that "As good as Walden House is, it seems to me that no matter how many positive internal changes take place in the residents, as soon as they return to spouses, friends, parents, etc., certain previous patterns get triggered unless the significant others are aided simultaneously."

Another member of the Parents Association, the wife of a resident, believes that "With a support group one can bear with the pressure of everyday life, while our loved ones are in Walden House. Group support is a time of giving as well as taking advice. With the group I feel part of the togetherness of a family, similar people sharing similar situations."

In addition, family therapy is provided for residents of Walden House and their own parents. The conditions and location of family counseling services are flexible, including short-term crisis work and long term therapy, communications workshops, positive parenting education and a variety of support groups for friends and relatives of drug abusers in treatment, at Walden House and in the community.

Field trips and various cultural, social and recreational activities are planned to provide positive interpersonal experiences for participating families. Through these activities peer support systems and self-help networks are being developed. Family members are being trained as peer counselors in the area of substance abuse.

A sliding fee scale has been developed so that families which can afford to pay for family therapy will help to support the program. The Parents Association has already undertaken a variety of successful fund-raising projects to help Walden House survive despite budget cuts.

CONCLUSION

The Parenting Program has been one of the most successful and consistent aspects of Walden House during the past four years. Since January 1982 there has been an average of 25 residents per month who have participated in the Parenting program. This is 25% of the entire population of Walden House. The Parenting Program has conducted 7 groups a month during the past two years with an average attendance of 10 residents per group. During this period there has been 17 field trips for residents and their families including trips to the aquarium, planetarium, museums, zoo, beach, and baseball games. Over 100 families have been helped in some way through Family Services at Walden House.

REFERENCES

Kaufman, E. and Kaufmann, P., eds., Family Therapy of Drug and Alcohol Abuse, Gardner Press, New York, 1979.
Nebelkopf, E., The Herbal Connection: Herbs, Drug Abuse and Holistic Health, BiWorld Press, Orem, Utah, 1981.
Nebelkopf, E., "Holistic Programs for the Drug Addict and Alcoholic", Journal of Psychoactive Drugs, 13, #3, 1981.
Nebelkopf, E., "Overview: Alcohol and Drug Abuse Treatment - Holistic Methods", Focus on Alcohol and Drug Issues, 6, #1, 1983.
Stanton, M.D., Todd, T., Heard, D., Kirschner, S., Kleiman, J., Mowatt, D., Riley, P., Scott, S. and Van Deusen, J., eds., The Family Therapy of Drug Abuse and Addiction, The Guilford Press, New York, 1982.

ADDICTION, MARGINAL PATHOLOGY & SOCIETY

Dr. Juan Alberto Yaria

Gradiva Therapeutic Community
Buenos Aires, Argentina

Addiction: A Marginal Pathology

What does an addict say he cannot say? A therapist should place himself in the boundary between what is being said and what is not. Everything the addict is showing should be put into words. His actions, marked with impulsiveness, violence, cheating, even bribing, should be given a real meaning by the analyst. This work is not intended to answer what psychiatric nosography the addict belongs to. It will deal with the inflections of narcissism and language, both elements which help give human shape to the subject and which operate within a social and institutional framework.

Family and social conflicts provide, in turn, the setting for certain universal premises forming part of what we know as culture. The passage into culture will imply the conflicting observance of the law forbidding incest and all its consequences for the cultural constitution of man.

Thus, leaving aside the nosographic approach to addiction, as it would make us fall in an individualistic psychiatry, I feel it is important to study the subjectivity (1) of the addict, supported by the two big myths discovered by psychoanalysis as shapers of human nature: Narcissism and the Oedipus Complex. These act within a family and social reality (where characters and roles are developed) with a background of cultural laws that determine the passage from the natural individual to the cultural subject.

From this point of view addiction is a pathology of the family, of civilization and of subjectivity, interlocked at different levels.

Subjectivity is also seen within a framework. Think of the Kairological time of the Greeks that is a time for trial. Each stage of life poses new questions. We may or may not have the answers. A failure in the trial leads to a unique "seizure" of the subject. Consequently, an addict is also somebody who has been "seized" while being questioned during the critical stages of life: puberty, adolescence, parenthood, etc.

The Addict as Slave: What He Says Without Saying

Think about the etymology of the word addict: it comes from *adictum*, meaning without diction or something not said. At the same time it means slavery. The words themselves suggest the idea: those things not said (feelings suppressed or held back) imply a state of slavery. When something is not told, somebody becomes a slave of an object which, in turn, becomes his Master. It is only when someone expresses himself that he achieves some degree of independence from the object. However, while being subject to an object like a drug, the addict is trapped (2).

In a chain reaction pattern addiction reveals different stages of the critical pathology of civilization. At the same time there is a failure in the family to provide symbolic support for the conflicting passage from the natural individual to the cultural subject. In the end, we have the actual patient who comes for advice, living through a specific stage of life, generally adolescence) (3). Are we surprised when we find out that the addict expects an early death and has a contempt for any kind of standards, even those derived from bodily functions? So I wonder: What does the addict criticize about us, the consumers of this culture? What does the addict criticize about civilization?

In my previous works I presented serious pathology as a criticism of society, as a mockery of a sound way of living. Addiction is a true statement mocking culture and civilization. It is a criticism of the social mask from an absurd point of view. When speaking of addiction, the truth remains "clogged", fixed in an answer that does not lead to any further questions. Unfortunately, this social criticism costs the addict his life.

The Pure Culture of Death Instinct

S. Freud wrote in *The Ego and the Id* , "What prevails in the Superego is like a pure culture of death instinct. Very frequently does the Superego succeed in driving the Ego to death if this does not protect itself from its tyrant and looks for shelter in mania."

In the case of addiction, this culture shows itself in the double sense of the word: cult and cultivation of death. Ethnopsychiatry-- of analytical inspiration--as well as sociology, since the unequaled studies of E. Durkheim, insist on certain mortifying features of our civilization. Ethnopsychiatry shows us the existence of a technological-rational ideal with an ethic based upon performance and the supremacy of anonymity in human relations, so leading to depersonalization and bureaucracy. Furthermore, there is a need to standardize tastes and values through propaganda which submerges the subject even deeper into a world of images. It is from this point of view that our civilization can be described in certain aspects as technophrenic.

From another standpoint, sociology speaks about the crisis suffered by a competitive society in relation to social standards. Anomie and its social response--suicide--are examples of this. Addiction (4) is a slow suicide that undoubtedly responds to certain constant social factors. Durkheim says, "Modern societies can be defined by their social disintegration and by the weak bonds linking the individual to the group."

Later on he teaches us, "Suicide is an individual phenomenon that responds to social causes." To this we must add the destruction of ethical systems developed by mankind over the centuries in order to reach an ethics of performance. This ethic is based upon the imaginary identification of the subject from the machine, the former being "swallowed" by the latter. Consequently, in this age when rational ideals are prevailing and when the fruit of false religious myths seem to have vanished from the time when Compte thought he had buried them, primitive religious forms reappear: fetishism of objects and images. All civilizations gave significance to images and to the fetishistic worship of creation, but the present one places more emphasis on it.

Ecclesiastes tells us, "Man eventually ends up by worshiping the work of his own hands." Man appears in the present human framework as a mass linked with technique and with planning. These characteristics raise the matter of power--as well as its perversion--to a highest category (5).

Power not limited by ethics and subject only to its own effectiveness generates the possibility of destruction. Everything that does not fit in the power system is immediately put aside. The outsider is then a mockery of the power system which is "aware of itself but self-deceiving." S. Freud caught a glimpse of this when he wrote *Psychology of Masses* and *Analysis of the Ego* (1921) (6).

Narcissism as a Collective Formation

Since *Psychology of Masses* and *Analysis of the Ego*, narcissism is not considered to belong to classificatory pathologies, but it is related to collective formations, to co-actions. Narcissism is also a mass formation. Modern propaganda, employing as a technique the negative use of images, is an example of it. These mass formations reveal themselves as a power. From this standpoint, addiction is a social disease. A social demand is created from the social environment. An object should be brought into the consumption market. Overproduction is the master. New consumers are required; they too must be created (7). The addiction symptom is related with the structure of power as its counterpart. How is the death instinct culture spreading? By means of the negative dialectics that link the seducer with the seduced. Another symptom, from this standpoint, is drug trafficking.

We will be able to observe the peculiar submission that the patient is actively showing, when looking at the relationship between seducer and seduced. This evil period involves all the effects and the incidences S. Freud mentioned in *Psychology of Masses* and *Analysis of the Ego* when referring to the submission to the double, in the very field of hypnosis. Somebody or something takes the place of the master, while the other becomes the slave. This pattern occurs in the patient's family. If this situation is not changed, the actual death of the addict will occur.

An analyst today should criticize the pretended ideals of power based upon a deadly narcissism. In this way a new ethic will arise that will not only bring an adjustment of an individual regarding the environment.

Family and Addiction

Family can be regarded as an intermediate stage of a symbolic type. The different characters and roles provide the setting. The psychoanalytic studies of the family disclose a special distortion: wish is not adjusted, shaped or adapted by any object. The subject finds in the family a law for his wishes and a way of entering into culture, but he also fails to find satisfaction.

The laws conditioning the human being (e.g., laws forbidding incest) find their inflection point in family "mythology" (8): wishes of the parents, transgenerational influences, parent-child relationship. Three generations sharing the shaping of the subject, creating generational covenants or rivalry.

The symbolic covenant among generations guarantees the possibility of planning for the future. On the other hand, rivalry leads to early death or to different psychopathological probabilities.

Narcissism, previously described operating in certain social formations, is also found in the family, thus clouding the symbolic pattern of kinship the family should be representing.

At the same time, the family function has lost its symbolic "weight", when it seems to be more necessary, due to different social reasons (9). J. Lacan already showed the deterioration of family relationships, the fall of the father image, when he spoke about "the coming of wicked godmothers to the cradle of the neurotic to be." This analysis was based upon the family arising from the first and second industrial revolutions. The problem gets even worse with the so-called third industrial revolution.

Character and Role

The role of the father becomes a turning point between the family and extra-family aspects. This role operates through characters who show their influence according to their desire to represent that role. So we

can observe that they may even hinder the mediation. They do not represent anything. They become lawmakers, lecturers, due to their intensive presence or absence. We are dealing with the narcissism of the father. From this point of view the father is immortal. There is no access to the stage of stage of the Dead Father, that is, dead to narcissistic identifications. We should recall Hegel's reflections in Jena: "Individuals are themselves death in process of becoming, but in the action of becoming dead, the action of becoming alive is implied."

The addict's family shows us a very special shortcoming as regarding the father as a representative of the law, because the actual father may be absent or intensively narcissistic -- dead, missing, humiliated, false, denigrated, a man consumed by the consumer culture. Or, on the contrary, he may be a marginal father, an outsider, resentful, violent, a robber who cannot obtain all the materialistic benefits that a consumer culture offers.

It is only in this interface of characters and roles (the symbolic patterns of kinship) that the interactions of the patient's family system may be analyzed. This symbolic pattern does not deny history. Quite the contrary, this is the basis of the generation gap, placing on the patient the burden of family background. The patient appears to be picked for family insanity; he is at the same time the scapegoat of the group and the sentry of his own pathology.

Family and Double Subjugation

In psychoanalysis family can be seen from two viewpoints: *famulus*, and *a femore*. The first, famulus, means groups of offspring, slaves and servants of a master. This meaning brings us closer to what a word imposes on us; conditions are ripe for double subjugation. In every family of seriously sick patients we can see that somebody is taking the place of some other, who becomes the Real Other of domination. The father, the mother, or the son will alternately play these roles, becoming lawmakers rather than representative witnesses. Different relationship modalities appear in these families: strong ties binding elements of different generations, weak ties binding elements of the same generation, inclinations to different forms of incest, sacrificing exogamy for the sake of endogamy.

Different stages of insanity are observed as a new form, "psychical inflection", suggested by Freud is taken up. The Dead Father who secures kinship for life does not exist. There is a father who is too alive bringing death forward.

The second viewpoint of family is *a femore* (10), in which family derives from femur, according to ancient writings defining genre and lineage. Lineage implies the long family ancestry and genre comes from generation: there are two of them, masculine and feminine. From this standpoint family follows the pattern of a living organism, defining the broad human areas, namely sexual difference, generational difference, and displacement from endogamy to exogamy.

Addict's Subjectivity

In my book, *Psychotherapeutic approach to Psychosis*, I describe the peculiar subjugation of the patient to his double. Relation with the symbolic other is substituted with the Real Other of domination (where the patient, or a significant relative alternately appears). A patient comes for advice. The father describes with surprise that his son has told him that he (the father) father was committing suicide. In fact the patient was right: his father was actually killing himself. But the patient--through his pathology--anticipated the death of the other by playing it himself.

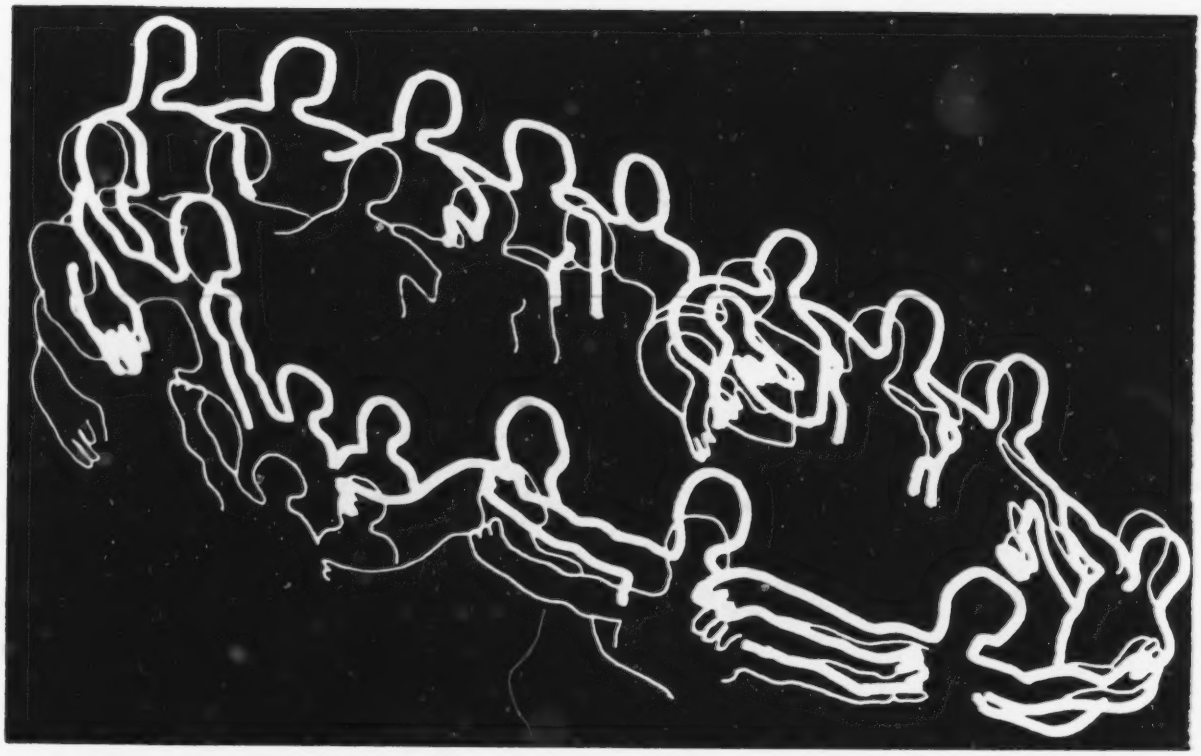
In the mirror-couple (imaginary relationship where language as effect of trust is fixed or clogged) the patient can only be revealed by himself in his action. What role was this patient playing? He goes out to the streets telling everybody he is God and attacks policemen. Consequently he is arrested. The symbolic Great Other, corrupted by him and by the owner of the patient (his father) reappears in what cannot be symbolized. Father for real exposing him to castration in real. This in turn exposes him to a peculiar seizure as he becomes an outsider with a criminal record. Not "listening" to significant readings seizes him. M. Heidegger's analysis on "listening to" and "seizure" may help us understand this particular situation. He is caught on two fronts: out of the symbolic circuit and condemned as an outsider. Further psychiatric treatment reinforces his marginality as he pays psychiatrist's fees with marijuana--a patient bribing a partially legal representative, who plunged him deeper into marginality.

Psychiatric and psychoanalytical lectures have different forms of clogging pathology: how can one stop speaking about what cannot be said?

REFERENCES

(1) Subjectivity is opposed to individuality. Subject implies a primeval division and does not refer to "substractum" but to subjugation. Therefore I am speaking of a "subjected subject". Individual means "not divided". The human being is subjected to a pre-existant symbolic order which he does not know.
(2) In this analysis I shall use the triple record: symbolic, imaginary and real, following the concepts of J. Lacan.
(3) It is very interesting to analyse adolescence in our technocratic society and even the difference between it and that of more primitive and traditional societies. It seems that in our civilisation adolescence is more conflictive, since the passage and initiation rites do not have the symbolic "weight" they used to have years ago. Besides, social problems such as the lack of creation of job opportunities in neighbor countries add new difficulties to the already hard times of living in society.
(4) In his celebrated thesis over suicide, E. Durkheim (1908) showed us the resulting from disorders caused by pathological consequences of work division and weakening of collective values. One of Durkheim's concerns was how a society could be kept alive and united with such a diversity of activities, work division and urbanisation.

(5) We will see the importance this has for the present therapeutic community. Psychiatric development is essentially personalizing in front of an unpersonalizing reality.
(6) Between the twenties and the thirties, interesting acts take place. M. Heidegger (1927) in Sein und Zeit gives us a warning over the anonymous world. In 1920 the National Socialist Party is formed.
(7) We only have to watch how the cocaine international price has dropped as a result of overproduction and the entrance of the Bolivian and Colombian markets in our country.
(8) J. Lacan in Myth and Truth in Psychoanalysis describes in detail the question of family mythology.
(9) We must study the passage from the traditional to the technotronic family, through the transitional family.
(10) San Isidoro de Sevilla: Etymologies B.A.C.



THE ADDICT AND HIS FAMILY IN THE TC

Dr. Miguel Angel Bianucci

Gradiva TC
Buenos Aires, Argentina

In this presentation, I wil try to differentiate the functioning of the family of the drug abuser from the family of the psychiatric patient.

First I would like to clarify the context of Gradiva Therapeutic Community. It is urban, private and has been working for 13 years treating chemically dependent patients and psychiatric ones. Up to now 1,500 patients have been treated at the institution, together with the family group. Twenty percent of the residents are drug abusers. We have treated 300 drug abusers and their families. Drug abuse in my country deserves an explanation of its peculiar characteristics.

Eighty percent of the drug abusers, excluding alcoholics and tobacco smokers, are addicted to inhalants and prescription drugs which are available at any drugstore. The most commonly used ones are anti-tussives containing codeine and anorexigens that get people high. The other 20% is distributed among those addicted to marijuana, amphetamines or a combination of both. When an adolescent with these addictive characteristics enters the community, we certainly meet an expert in pharmacology. Cocaine abusers are growing due to the decrease of the international price of cocaine, but hard drugs such as heroin are quite unusual. We have only treated two heroin abusers.

The way in which psychiatric patients and their families enter a therapeutic community will differ according to the type of mental disease. Such is the case of schizophrenics, melancholics, suicidal clients, manic-depressives and their own families. This has been described widely by several authors, such as Harold Searles, Jay Haley, Nagy and Carl Whittaker, who have developed investigation on the way these mentally disordered families behave. For psychiatric patients the psychoanalytical and psychiatrical trend is very clear about the different therapies: individual, family, milieu and chemotherapy. Generally speaking these branches of investigation have not yet deeply studied the subject of the drug abuser and his family.

As far as I know, the culture of the drug abuser and his family culture are quite different from the culture of the previously described patients. This culture is neither psychiatric nor neurotic. Although we could observe that some chemically dependents and their families show psychotic or neurotic characteristics, I cannot go into considerations on this subject because this psycholopathologic description exceeds the length of time I was given for my presentation.

I will try to make up a brief summary of the development of impulsive sociopathic traits. An early muscular maturity that allows the invidivual to have a good handling of space is discordant with the capacity to integrate body and word-phrase representation; these people also have some difficulty in the ability to integrate space experiences with the succession of facts that have taken place in their lives. From a family point of view, we have a mother who lacks empathy and a father with difficulty in performing a protective role. I will call him an "ambiguous father." This is a different role than the absent father of the psychotic. The ambiguous father does not teach delayed gratification so that the addict never learns that he cannot get all he needs at the very moment, but has to wait. We will see how this situation is repeated in the model of behavior a drug abuser uses to enter the community.

Following the development of this sociopathy we can point that once it has settled in the personality, the patient will not be able to grasp the meaning of rules that will enable him to develop interpersonal therapeutic relationships. Sociopaths move on the basis of false assumptions. In relationships they learn: 1) to frustrate; 2) to transform the other one as a reflection of oneself; 3) to possess the other person and use him to promote intrigues; and 4) to praise the ego ideal of a person to influence the other person demagogically.

With time these impulses have become egosyntonic. It is not that they cannot control disrupting impulses, but that these have become so attached to their personality that their scale of values and their attitude toward what they send to others and what they receive from others has acquired an ethical dimension such that they despise people living in groups under common ethical laws. This constantly segragates them from the people who might gratify them. While they stick to unstable groups they suffer from loneliness and anxious depression.

Up to now, I have developed the family and the genetic-evolutive points of view. I would like to explore the social angle in the genesis of the chemically dependent character. Most of us, to a certain extent, are submerged in what is called consumer-oriented ethics. I would like to point out that our culture has created the need to consume. This has gone so far that although it seems a paradox, man is the one that is being consumed. No matter how; the important thing is to consume. Within this relatively modern ethic, I would add one more ingredient--the modern global village--where information is known instantaneously through the media. Through satellites we can can have the whole world at hand before our eyes and ears, with the different mixture of cultures and beliefs.

I would like to share these reflections with you. I think that psychoanalysis, through Freud, could decipher what the insensibility of the psychotic meant; that it is an attempt to get cured, an attempt to give an explanation. Similarly, chemical dependency could be construed as a strategy of coping in an alarming and ambiguous social environment based on the consumer oriented market.

Through my experience, the person that enters the therapeutic community will try to make us accept his transgressions to the rules and become his accomplices in certain actions that break the fundamental rules needed to live in a therapeutic community. The family influence on the patient shows through his manipulations to break the time limits he has been given set for treatment. In individual treatments, the therapist must pay attention to the impulse code that leads to action and implement an adequate non-technical language.

In order to protect the culture of the community, the members of the staff and the patients must have a flexible attitude, not a rigid one, of getting patients to confrom to the rules they will try to trangsress. The attitude of the community should be firm but understanding as this will diminish their self-destructiveness and will enable them to develop a sense of hope in life, to discover positive affective values, to become an agent of reflection who carries a message for our society, to understand that not everything is apocalyptical in life, to believe that life is worth being lived, that it should be lived, and that we must work hard for it.

In conclusion, I will define the therapeutic community as a counter culture for the chemically dependent patient. Sometimes, the therapeutic community is the only social support he has in the world, and it becomes very difficult to help him to resocialize. This is the case of the psychiatric patient, too. This faces us again with a social problem. The basic modification should point out to a change in social structure in which the human being should not be a mere object to be discarded.

THE MALE BATTERER

Ricardo A. Carrillo, Ph.D.

Walden House, Inc.
San Francisco, California

The purpose of this study was to provide empirical psychological data on the male batterer in order to determine what variables are associated with wife abuse. Domestic violence has recently received considerable attention in the psychological literature (Walker, 1980), but researchers and service providers have focused on the battered woman (Star, 1978), paying little attention to the male batterer (Morgan, 1982); Rosenbaum & O'Leary, 1981). Granted that concentration on the immediate needs of the battered woman is appropriate, the ultimate reduction of abuse requires that we investigate the variables that contribute to a man's violent behavior toward his spouse. The man who physically batters a woman more than once during an intimate marital or marital-like relationship has been designated as a batterer.

Not all individuals who experience violence are batterers or battered women. The above definition differentiates violent spouses from others. It is a known fact that violence escalates in frequency and severity (Browne, 1983, Walker, 1980).

Domestic violence has been categorized into four distinct types as defined by the Family Violence Project (Sonkin & Durphy, 1982). The four types are: a) physical violence, b) sexual violence, c) destruction of property and pets, and d) psychological violence.

Physical violence refers to any physical action that forces another to do something against his or her will. Examples of physical violence include hitting, choking, pushing, grabbing, slapping, punching, hitting with weapons or objects, etc.

Sexual violence is defined as forcing another individual to have sexual intercourse or other sexual activities including rape, oral and anal sex, forces sex with animals, other people, or with objects. Thyfault (1980) studied a sample of 432 battered women and reported more than 50% of that population reported sexual abuse.

Destruction of property includes the breaking of any personal property, property of the spouse, including pets. Examples may vary from breaking dishes to killing the family dog. This type of violence adds to the psychological intimidation of family members.

> Psychological violence is defined as: name calling...it includes intense and continuous mental degradation; controlling someone's actions, behavior, etc., by threatening his/her well being; psychological manipulation that may be a form of brainwashing, or rigidly controlling someone's actions or behavior by psychological manipulation (Sonkin & Durphy, 1982, p. 12).

The increasing prevalence of domestic violence demonstrates the need for interventions. Legal, social, moral/ethical, and psychological approaches to the prevention, treatment, and rehabilitation of battered women and male batterers should increase. Research on the male batterer is almost nonexistent (Chomet-Petrovich, Zillman, & Sobocienski, 1980), yet treatment programs for these men have been implemented with minimal verification of the variable involved (Foreman & Fredrick, 1981; Sonkin & Durphy, 1982). Literature on domestic violence and male batterers has been descriptive in nature with little empirical data to substantiate the findings (Elbow, 1977; Shaniness, 1977). How is it possible to plan effective psychological interventions if variables associated with the male's violent behavior have not been verified? This study attempted to contribute to the literature by filling the gap between theory and the demand for services.

Domestic violence is a crime against women (Walker, 1980). Traditionally, crimes against women are a direct manifestation of an oppressive patriarchal ideology. Patriarchy implies that women and children need to be protected. Therefore, the need for protection allowed the patriarch to view his family members as "property." The notion of property led to the establishment of common law (Morgan, 1982), thereby cementing the belief of women as property of the patriarch. Morgan (1982) and Davidson (1978) reviewed the literature with regard to the establishment of "common law" and crimes against women, as it relates to domestic violence. The reader is referred to these sources for a rich elaboration on the subject.

In regard to the present study, it is necessary to understand how deeply embedded are Western society's beliefs of men as patriarchs and women as property. Pagelow (1981) postulated the highest prediction of women battering to be "traditional ideology." According to Pagelow, "traditional ideology is a range of internalized beliefs in the acceptance of the 'rightness' of the patriarch-hierarchical order of the social structure" (p. 40).

Presently, "traditional ideology" has its basis in early patriarchal notions and serves as the best predictor of domestic violence. Masculine traits that perpetuate notions of "strength," "authority," "protectors," etc., are adhered to by both male batterers and battered women alike (Pagelow, 1981). This study illustrates how male batterers learn authoritarian beliefs and how they are reinforced by the family and society.

The purpose of this study was to determine the variables associated with a man's violent behavior toward his spouse. The verification of the variables under investigation would allow the clinical community to focus on these variables that have a significant relationship to domestic violence. Intervention strategies could be better implemented at the primary, secondary, and tertiary levels of prevention. The assessment, treatment, and rehabilitation of violent men could then be directed toward those areas that have demonstrated a significant relationship to violence in the home.

Social Learning Theory

A theoretical social framework was used to explain the contingencies by which batterers learn and maintain their violent behavior.

The use of social learning principles allows the clinician to view the treatment of the batterer as a learning process with the following assumptions: a) There is hope for the batterer; b) since violence is a learned behavior, alternative behaviors can be learned; and c) the batterer is forced to take responsibility for his behavior rather than to attribute the blame to his "pathological nature." The primary focus of this study was limited to the male's contribution to the violence in the home. The woman's contribution to the violence was excluded, following the rationale that it is the male who is ultimately responsible for his own behavior. This is not to say, however, that women do not become violent. Recently, women have received attention for violence committed against their spouses (Brown & Wampold, 1983; Browne, 1983). This study was limited in its focus of the male as a protagonist of the violent episode.

The use of a multivariate statistical analysis, specifically the discriminant function techniques, provided the researcher with a method to analyze quantifiable data that may identify the significant psychological variables related to domestic violence.

Variables Associated with a Batterer's Behavior

The literature indicates that it may be possible to identify a "violence prone personality" (Walker, 1980). According to this hypothesis, characteristics of this personality include a history of family violence (i.e., witnessing and receiving violence in the childhood home), criminal record, lack of assertion, alcoholism, extreme traditional sex role expectations, conservative sexual attitudes, insecurity, tension, and possessiveness (Rosenbaum & O'Leary, 1981; Sonkin & Durphy, 1982; Walker, 1980).

The major source of this hypothesis stems from victims' reports or clinical observation (Elbow, 1977; Shaniness, 1977; Sonkin & Durphy, 1982; Walker, 1980). A paucity of empirical studies exists that has directly interviewed batterers and utilized standardized psychological measures to test this hypothesis.

The following variables were selected for investigation: a) history of family violence; b) traditional sex role expectations; c) personality characteristics of insecurity, tension, possessiveness, assertion; and d) conservative sexual attitudes.

The study was conducted in two phases: a structured interview was conducted individually with the subjects, and a battery of standardized psychological measures was administered.

Method

A matched group design was utilized in this study. Research subjects were matched on demographic variables with a clinical control group. The researcher was interested in identifying the discriminating variables associated with the male batterer's violent behavior. Thirty-eight identified male batterers were "matched" with 20 men in treatment at community mental health centers who were being treated for problems not related to domestic violence, psychosis, or neurological impairment. The extraneous demographic and treatment factors were controlled in order for the predictor variables to discriminate between the male batterers and members of the clinical control group.

The structured interview was facilitated by the use of Starr, Clark, Goertz, and O'Malai's (1977) Psychosocial Inventory that measured quality of life in childhood, adolescence, adulthood, history of violence, and patterns in significant relationships. The Cattell 16 Personality Factors (16 PF) (Cattell, Eber, & Tatsuoka, 1970) was used for the measurement of personality variables. Attitudes Toward Women (ATW) (Spence, Helmreich, & Stapp, 1972) measured sex role expectations. The Thorne Sex Inventory (SI) (Thorne, Haupt, & Allen, 1966) measured sexual attitudes.

Results

A stepwise discriminant function analysis (Wilks's lambda) was utilized to distinguish the best discriminating variable that would differentiate the two groups (Klecka, 1975).

The variables selected to discriminate between the batterer group (n = 38) and the control group (n = 20) were: a) history of violence; b) Cattell 16 PF scales--C-, easily affected by feelings; E+, authoritative; L+, suspicious; Q1-, conservative; Q4+, tense; c) conservative sex role attitudes as measured by the ATW; d) Thorne Sex Inventory (SI) subscales--B, sexual maladjustment and frustration; C, neurotic conflict associated with sex; D, sexual fixations and cathexes; F, loss of sex controls. The Cattell 16PF has 11

additional personality factors and the SI has five other scales that were also included in the analysis. The purpose of this was to see if the other measures were better predictors of differentiating between the two groups than the variable selected from the literature.

A discriminant function analysis was utilized to enter the most significant variables. A multiple regression was used to analyze the contribution of the most significant variables selected in the discriminant analyses.

Multiple Regression

A multiple regression analysis was conducted to assess the relationship among the selected prediction variables (SIA, SID, ATW, PFO, PFI, PFQ1, PFQ4) and the dependent variable subject group (Batterer: Control). The multiple regression is described in a stepwise fashion.

The groups appear to cluster on a dimension of "conservatism vs. liberalism" as defined by Thorne et al. (1966). The control group differs from the batterer group is scoring in a higher direction on SIA (.48), SID (.36), PFI (.21), and ATW (.23). The batterer group differed from the control group on the measures PFQ4 (-.21) and PFO (-.27).

Batterers appear to experience less sexual drive and interest (SIA) as well as less sexual fixations and cathexes (SID) in comparison to the control group. They seem to be more tense (PFQ4) and more insecure (PFO) than their clinical counterparts. PFQ4 and PFO are two of the six 16 PF dimensions that comprise the second order anxiety factor on the Cattell 16 PF (Krug, 1981).

The control group members appeared to compare themselves with Thorne et al.'s (1966) "liberal" end of the continuum of sexuality. They portrayed themselves as experiencing more sexual drive and interest (SIA) than the subject group. They scored considerably higher on fixations and cathexes (SID) than the batterer group; they scored slightly more liberal on their attitudes toward women (ATW) than the batterer group; and were more sensitive (PFI, r = .30 with ATW + .23 with group) than the batterer group.

In summary, the batterer group was: a) more tense than the control group, b) less sexually interested than the control group, and c) more insecure than the control group.

Discussion

This study had a twofold purpose. One was to provide empirical psychological data on the male batterer. Secondly, an attempt was made to differentiate male batterers from the general clinical population. The intent of the researcher was to provide information for the clinician that would help him or her become more effective in the assessment and treatment of male batterers.

A minority of clinicians has the necessary information to assess accurately when a batterer is in the consulting room. The aim of this research project has been to assist the clinician in this task.

It was established that batterers did not differ from the general clinical population with regard to violence in the family of origin. These results indicate that men who were abused as children or who observed spousal abuse do not necessarily become batterers. Also, the proportion of violence in the home experienced by both groups was equal. The implications are that a history of violence may be prevalent in the general clinical population, and that a large percentage of men (50%) who experience violence in their family of origin may not batter their spouse, but may manifest other psychological problems.

The groups differed on a measure of sex role attitudes. The scores on the ATW for both groups were significantly higher than in previous research (Rosenbaum & O'Leary, 1981). Rosenbaum and O'Leary (1981) reported scores in the 30s and 40s for the battering group and the marital dysfunctional control group, respectively. The scores of the battering and control groups in this study were in the 50s, indicating a considerably more liberal view of women. A confounding effect of "social desirability," a trademark of all objective psychological measures, is purported to account for the higher scores in this study. In our modern society it is socially desirable for men to be more liberal in their attitudes toward women.

It was also established that the battering group was more conservative in their sexual attitudes than the control group. Thorne et al.'s (1966) research differentiated college students and drug addicts to be more liberal in their sexual attitudes than felons or sexual offenders. The control group in this study portrayed a similar profile. The battering group's profile on the SI was closer to the felons' than to the sexual offenders. Batterers portrayed lower sex drive and interest and denied conscious feelings of sexual deprivation, frustration, and problems with loss of sexual control.

Theoretical Implication

The two groups involved in this study did not differ statistically in regard to their history of family violence. Forty-eight percent of the battering group and 50% of the control group did come from violent homes. These subjects were questioned in a structured interview about what the quality of their life was prior to age 12. A majority of those abused as children felt that the discipline they received, no matter how severe, was deserved. However, opportunity for the acquisition of violent behaviors was equal for both groups. Social

learning theory accounts for this phenomenon by the observation that "psychological function is a continuous reciprocal interaction of personal environmental determinants. Within this approach, symbolic, vicarious and self-regulatory processes assume a prominent role" (Bandura, 1977, p. 12).

Modeling may serve as a means to learn a variety of behaviors. However, this theoretical perspective lends support and credibility to the individual's ability to develop cognitions necessary for "self-regulatory capacities" (Bandura, 1977, p. 13). Inherent within this perspective is the notion that an individual can choose to behave in a variety of ways in response to an environmental antecedent. The men in this study demonstrated a variety of responses to conflict, stress, and frustration. Violence was only one response. Anxiety, depression, suicidal ideation, social isolation, drug/alcohol abuse, severe impairment in forming social and intimate relationships were other responses the men chose.

Growing up in an environment that stereotypes boys and girls dichotomously produces rigid sex role expectations. A second order effect of this phenomenon is that it makes boys anxious, insecure, and tense, particularly when they believe that they need to live up to an "idealized masculine image."

Summarizing the theoretical implication of the results of this study, it was found that individuals develop idiosyncratic cognitive processes to respond to similar environmental stimuli. Although the types of responses may have been maladaptive, a variety of different responses was evident.

Clinical Implications

The results in conjunction with the researcher's recent clinical experience suggest that batterers are psychologically "fragile." The heightened amount of insecurity, the intensity of their inner tension, and chronicity of their anxiety highlight the need for a strong, safe, therapeutic relationship. The tremendous need for "putting on a good front" may be recognized by the clinician as necessary for the psychological integrity of the batterer. However, the clinician need not be swayed or seduced by the false social competence of the batterer. The metaphor of "Jekyl and Hyde" may be a useful one to remember when assessing, in the consulting room, the potential for lethality of the individual at home.

With respect to the rigid traditional sex role expectations, therapeutic interventions could be structured to assist batterers in learning flexibility. The exploration of the individual's sexual relations and the underlying concerns appears to be necessary in psychotherapy. On a preventive note, the results of this study indicate a need for our society to promote non-traditional sex role expectations. The learning process in the home and the subsequent societal contingencies that promote non-aggressive means of conflict resolution are necessary if the amelioration of domestic violence will occur.

REFERENCES

Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice-Hall.

Brown, J., & Wampold, B.E. (1983). Predictors of Abused Wives' Own Level of Violence. Paper presented at the Rocky Mountain Psychological Association, Snowbird, Utah.

Browne, A. (1983). When Battered Women Kill. Unpublished manuscript.Cattell, R.B., Eber, H.W., & Tatsuoka, M.M. (1970). Handbook for the Sixteen Personality Factor Questionnaire (16PF). Champaign, IL: Institute of Personality & Ability Testing.

Chemet-Petrovich, A., Zillman, L., & Sobocienski, P. (1980). Report on the 1980 Threshold Domestic Violence Treatment Program. Submitted to the Domestic Violence Treatment Board, Michigan Department of Social Services.

Davidson, T. (1978). Conjugal Crime: Understanding and Changing the Wifebeating Pattern. New York: Hawthorne.

Elbow, M. (1977). "Theoretical Considerations of Violent Marriages". Social Casework, 58, 515-526.

Foreman, R., & Fredrick, M. (1981). Training Manual on Domestic Violence. Santa Barbara, CA: Family Violence Program.

Klecka, W.R. (1975). "Discriminant Analysis" in H.H. Nie, C.H. Hull, J.G. Jenkins, K. Steinbrenner, & D. Bent, Statistical Package for the Social Sciences (SPSS), pp. 434-467. New York: McGraw-Hill.

Krug, S.E. (1981). Interpreting 16pf Profile Patterns. Champaign, IL: Institute for Personality & Ability Testing.

Morgan, S. (1982). Conjugal Terrorism: A Psychological and Community Treatment Model of Wife Abuse. Palo Alto, CA: R-E Research Association.

Pagelow, M.D. (1981). Woman-battering: Victims and Their Experiences. Beverly Hills, CA: Sage.

Rosenbaum, A., & O\Leary, K.D. (1981). "Marital Violence: Characteristics of Abusive Couples". Journal of Consulting and Clinical Psychology, 49, 63-71.

Shainess, N. (1977). "Psychological Aspects of Wifebeating" in M. Roy (Ed.), Battered Women: A Psychosociological Study of Domestic Violence (pp. 111-118). New York: Van Nostrand Rinehold.

Sonkin, D., & Durphy, M. (1982). Learning to Live Without Violence: A Handbook for Men. San Francisco: Volcano Press.

Spanier, J.T., Holmreich, R., & Stapp, J. (1972). A Short Version of th Attitudes Toward Women Scale. Princeton, NJ: Princeton University Press.

Star, B. (1978). "Comparing Battered Women and Non-battered Women". Victimology, 3, 32-44.

Star, B., Clark, C.B., Goetz, K.M., & O'Malia, L. (1977). "Psychosocial Aspects of Wife Battering". Social Casework, 58 17-25.

Therne, P.C., Haupt, T.D., & Allen, R.M. (1966). "Objective Studies of Adult Male Sexuality Utilizing the Sex Inventory". Journal of Clinical Psychology, Monograph Supplement, 21, (whole monograph).

Thyfault, A. (1980). Sexual Abuse in the Battering Relationship. Unpublished paper presented at the Rocky Mountain Psychological Association, Denver, CO.

Walker, L. (1980). "Battered Women". In A. Brodsky & R. Hare-Mustin (Eds.), Women in Psychotherapy (pp. 339-364). New York: Gilford Press.